**Keywords** Smoking cessation/Smoke-free/Health coaching/Mental health

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## In this article...

- The drive towards smoke-free mental health services
- An intervention to help mental health staff stop or reduce smoking
- Smoking cessation support options, including nicotine replacement

# A smoking cessation intervention for staff in mental health services

## Key points

1. **Smoking prevalence among mental health nurses is estimated to be 17-40%**
2. **Nurses are at the front line of persuading service users to try to stop smoking, so they need to be encouraged to stop themselves**
3. **Trained and qualified advisers are key in helping staff to stop, or abstain from, smoking at work**
4. **Health coaching aims to encourage people to take responsibility for making lifestyle and behaviour changes**
5. **A smoking cessation intervention can be a cost-effective way to improve staff's health and wellbeing**


ALAMY

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**Abstract** An NHS trust providing specialist mental health services has put in place a smoke-free policy and supported staff to either abstain from smoking while at work or stop smoking completely. This article describes the intervention, which was carried out by specially trained smoking cessation advisers, and discusses its outcomes so far. Among staff who had signed up to a four-week attempt at quitting, half achieved their goal. Critically, the intervention – which was offered to all staff, both clinical and non-clinical – reached nurses who can play a crucial role in persuading service users to try to stop smoking.

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The National Institute for Health and Care Excellence recommends that all people who either use or work in mental health and secondary care services should be encouraged to stop or abstain from smoking and be offered nicotine replacement therapy (NRT) (NICE, 2013). The data on smoking prevalence among mental health staff in the UK is sparse; the figure among mental health nurses is thought to be somewhere between 17% and 40% (Royal College of Physicians and Royal College of Psychiatrists, 2013). While the adult smoking prevalence has dropped below 20% (Health and Social Care Information Centre, 2015), there is a perception that smoking among NHS staff is higher than in the general population.

In April 2016, Leeds and York Partnership Foundation Trust, which provides specialist mental health and learning disability services to people in Leeds and parts of York, became a smoke-free organisation. It put in place smoke-free policies in all its buildings, grounds, car parks and vehicles, and committed resources to help staff either abstain from smoking while at work or stop smoking completely.

### Staff's smoking status and behaviours

The trust had little information about the smoking status of staff or their interest in smoking cessation support. In February 2016, an electronic survey (paper-based for staff without access to email) elicited information from staff about their smoking status, smoking behaviours and attitudes towards potential support to quit.

All trust staff (around 2,500) – clinical and non-clinical, directly employed, agency and contracted – were invited to take part and 678 (27%) replied; 23% of respondents were registered nurses, 17% were nursing assistants or healthcare support workers and 17% were allied health professionals; the remainder came from a wide range of clinical and non-clinical groups. Responses are summarised in Table 1.

Overall, 131 respondents (19%) identified themselves as current smokers. This is in line

with the 18% smoking prevalence in Leeds, but higher than the average of 16.9% in England (Public Health England, 2016). Among these 131 smokers, there was a high level of interest in giving up (48%) or cutting down (22%). A high proportion (73%) smoked during working hours and more than half (52%) had tried to quit in the previous year.

## A bespoke intervention

From the survey results we concluded that a bespoke smoking cessation intervention was needed to meet staff's needs. A health improvement specialist from Healthy Living Service (and first author of this article) led the development of the intervention (Fig 1). The initial offer of support was made in March 2016 to coincide with National No Smoking Day (8 March) and the intervention was rolled out between March and October. Smokers were offered support to either:

- Abstain from smoking while at work;
- Attempt to quit smoking over a four-week period.

The intervention was delivered by nine smoking cessation advisers who were trained free of charge by the Leeds Stop Smoking Service. Training included face-to-face sessions with experienced advisers and completion of the National Centre for Smoking Cessation and Training online assessment. The trust's communication team promoted the intervention via email. A mailbox was created to allow staff to make confidential enquiries to the Healthy Living Service; these were followed up within two days.

Respondents were offered a one-to-one appointment with an adviser at a mutually convenient time and place. At this initial appointment:

- Their individual needs were assessed;
- Their goal clarified;
- A support plan agreed on.

A central feature of the intervention was the use of health coaching techniques. Health coaching aims to increase individuals' awareness of the need for lifestyle and behaviour changes, and encourage them to take responsibility for these changes, rather than rely on a health practitioner to make them happen (Moore, 2013).

## Staff who wanted to stop smoking

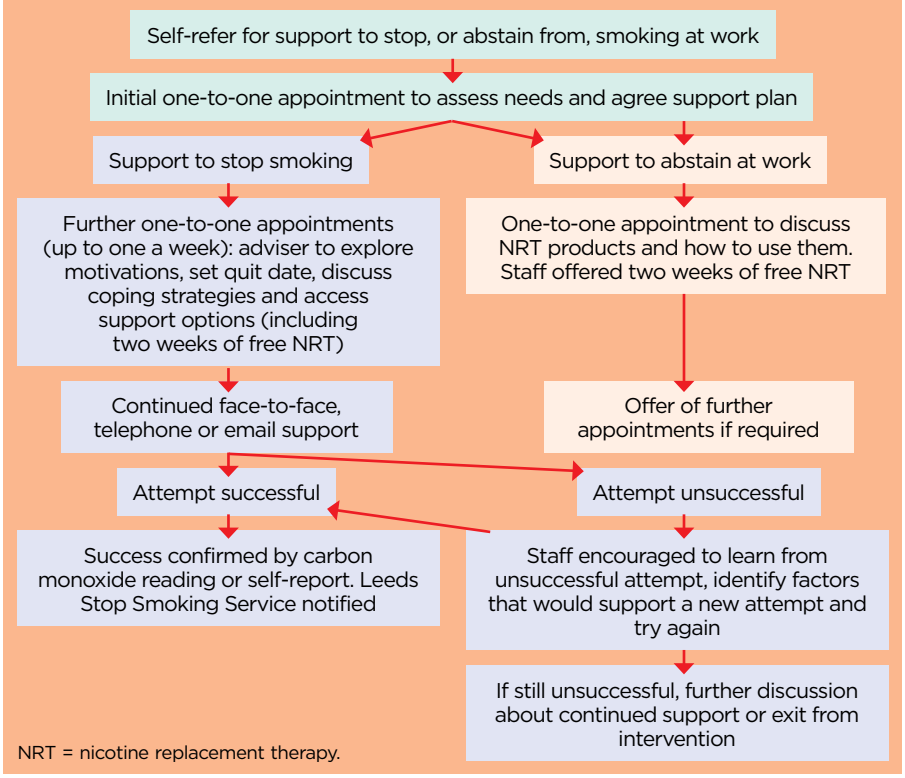
Staff who wanted to stop smoking were encouraged to set a quit date and use a carbon monoxide monitor to take readings of their carbon monoxide levels, which are elevated in smokers at baseline and during the four-week quitting attempt period.

Table 1. **Staff survey: smoking status, behaviours and views**

| Question | Answer | Staff (*n*) | Staff (%) |
|---|---|---|---|
| Smoking status (*n* = 678) | Current smoker | 131 | 19 |
| | Ex-smoker | 241 | 36 |
| | Never smoked | 303 | 45 |
| | Did not say | 3 | <1 |
| Smoking behaviours (*n* = 131) | I smoke and I want to give up | 63 | 48 |
| | I smoke and I want to cut down | 29 | 22 |
| | I smoke and I do not want to give up | 35 | 27 |
| | Did not say | 4 | 3 |
| Do you smoke at all during working hours? (*n* = 131) | Yes | 96 | 73 |
| | No | 31 | 24 |
| | Did not say | 4 | 3 |
| Have you made an attempt at quitting in the last year? (*n* = 131) | Yes | 68 | 52 |
| | No | 60 | 46 |
| | Did not say | 3 | 2 |
| Would you be interested in any of the following being made available at or by your workplace?* (*n* = 131) | Nicotine replacement therapy (patches, gums, etc) | 67 | 51 |
| | Group-based support | 13 | 10 |
| | One-to-one specialist support | 27 | 21 |
| | Telephone counselling and helpline | 6 | 5 |
| | Self-help materials | 23 | 18 |
| | None of the above | 40 | 31 |

*Staff could give more than one response to this question.

Fig 1. **The smoking cessation intervention**




NRT = nicotine replacement therapy.

These were useful motivation tools that gave staff a clear goal and provided objective measures of their progress.

Staff received information on NRT and non-NRT support options, and were offered two weeks of free NRT. Non-NRT options were one-to-one specialist support sessions and self-help materials.

During the four-week quitting attempt, staff and advisers also discussed progress, withdrawal symptoms and coping strategies; at the end of the four weeks, advisers met with staff once more or spoke on the telephone to find out whether their attempt had been successful. Staff's smoking status was checked using carbon monoxide readings or self-reports if this was more convenient for them.

### Staff who wanted to abstain from smoking at work

Staff who wanted support to abstain from smoking during working hours were given advice and encouraged to use NRT. Individual appointments were organised with advisers, who recommended an appropriate combination of NRT products for use at work. Staff were given two weeks' worth of free NRT and offered the possibility to make future appointments to assess their progress and consider smoking cessation support.

## Uptake and outcomes

In total, 58 members of staff contacted the Healthy Living Service, among whom:

- 22 signed up to a four-week attempt at quitting;
- 25 chose to access support to abstain from smoking while at work;
- 11 were lost to follow-up.

Among the 22 who tried to quit smoking, four (18%) were men and 18 were women (82%); one was a doctor, nine were nurses, three were health support workers, one was an associate practitioner, six were non-clinical workers and two were domestic staff. Their attempts at quitting resulted in:

- 11 having stopped smoking at the end of the four-week period;
- Seven exiting the intervention after relapsing;

The remaining four people were lost to follow up.

Table 2 lists the NRT products used by staff who tried to stop smoking. Most used a combination of two products, which is in line with NICE (2008) guidance. The most popular products were patches and mouth spray; this is consistent with indicative levels of nicotine dependency and the efficacy of NRT products. No one chose nicotine gum.

Table 2. **NRT products used by staff (*n* = 22)***

| Product | Staff, *n* |
|---|---|
| Nicotine patches | 16 |
| Nicotine mouth spray | 9 |
| Nicotine inhalator | 7 |
| Nicotine lozenges | 5 |
| Varenicline | 2 |
| E-cigarettes | 2 |

*Staff could use more than one product.
NRT = nicotine replacement therapy.

**QUICK FACT**
**17-40%**
Smoking prevalence among mental health nurses in the UK

## Discussion

It is encouraging that a high number of staff sought support, and this backs the results of the initial survey. The issue of smoking in mental health services was high on the agenda throughout the organisation, which may have encouraged staff to take up the offer of support.

Of the 22 who tried to stop smoking, 11 (50%) had achieved their aim at the end of the four-week period, which is comparable to the national smoking cessation service rate of 51% (NHS Digital, 2016). Nine out of the 22 who tried to quit were nurses, so the intervention reached some staff members who are at the frontline of persuading service users to try to stop smoking. The paradox is that while, as health professionals, mental health nurses know about the damaging effects of smoking, smoking prevalence among them remains relatively high.

Anecdotally, staff have reported that some of their colleagues who used to smoke were prompted by the smoke-free policy to voluntarily quit without support. This suggests those who used the intervention may have been high-dependency smokers who needed a combination of NRT and behavioural support.

A unique feature of the intervention was that it was delivered by fully trained smoking cessation advisers in the trust. In their feedback, staff reported high levels of satisfaction with the intervention, in particular with the flexibility of the appointments, which they found helpful. They also reported that seeing a qualified adviser who worked for the trust and understood the type of work they did was important.

As part of the support plan, all staff could receive two weeks of free NRT; this was financed by the trust's smoke-free project budget, which had been secured by the Smoke-free Task and Finish Group. The cost of providing two weeks of free NRT to 58 staff came to just under £2,300.

We do not yet have data on how much the trust might save as a result of the intervention in terms of reduced sickness absence and reduced smoking breaks. The trust's clarification of staff's entitlement to breaks has led to a reduction in the number of unofficial smoking breaks. Some staff reported that ensuring smokers only take legitimate breaks helps because people feel that everyone on the team, regardless of smoking status, is present in the workplace in equal measure. This could contribute to better team cohesion.

## Conclusion

To our knowledge, this is the only evaluation of a bespoke smoking cessation intervention offered to staff in an NHS mental health setting implementing a global smoke-free policy. Investing in the training and support of the advisers who carry out the intervention appeared to be essential. We do not yet know whether the smoking prevalence among the workforce has changed since the intervention, but we are planning to repeat the staff survey later this year, which will hopefully provide comparative data.

Such an intervention can be a cost-effective way of improving staff's health and wellbeing, and provides a great opportunity to link them to the wider public health agenda, which underpins the drive to reduce smoking in people who use and work in mental health services. **NT**

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